

# Home Treatment as an Alternative to Hospital Admission for Mothers in a Mental Health Crisis: A Qualitative Study

Hind Khalifeh, M.A., M.R.C.Psych.

Catherine Murgatroyd, B.Sc., M.R.C.Psych.

Mona Freeman, B.Med.Sci., M.R.C.Psych.

Sonia Johnson, D.M., M.R.C.Psych.

Helen Killaspy, Ph.D., M.R.C.Psych.

**Objective:** This study explored the experiences, treatment preferences, and needs of mothers of dependent children who were treated at home as an alternative to hospital admission for an acute severe mental health crisis. **Methods:** In this qualitative study, mothers were recruited who were treated by one of four crisis resolution teams in two inner London boroughs. Semistructured interviews were conducted with 18 mothers and five of their children. Transcripts were coded by thematic analysis to extract relevant themes. **Results:** Home treatment provided good patient care, but most participants felt that they struggled to parent adequately and to meet their children's needs. Common difficulties included meeting the children's physical needs, feeling emotionally distant, being dependent on children during the crisis, and struggling to protect the children from exposure to symptoms or distress. Most mothers preferred home treatment to hospital admission, because they felt safer and better looked after at home. However, most children preferred parental hospital admission, because it relieved the children of distress and responsibility. Mothers were reluctant to seek help with parenting from professionals because of fears of custody loss. **Conclusions:** Home treatment for female patients with child care responsibility meets patients' needs, but their children may be exposed to additional risks and currently lack appropriate support. The needs of children should be considered in the planning of home treatment for psychiatric crises. (*Psychiatric Services* 60:634–639, 2009)

In the United Kingdom 30% to 60% of patients with severe and enduring mental illness have children (1,2); similar figures have been reported in the rest of Europe and North America (3). Recent international service development has led to

the promotion of intensive home treatment as an alternative to hospital admission. The impact of acute parental illness on families is likely to differ when patients are treated at home or in a hospital. However, no studies have examined the impact of

home treatment on parents and their children.

Model services delivering intensive home treatment as an alternative to hospital admission have been tested over the past 40 years in a variety of countries, including the United States, Australia, the United Kingdom, and France (4,5). In 2000 the United Kingdom was the first country to mandate the national introduction of intensive home treatment teams or crisis resolution teams (CRTs) (6,7), adopting a model derived mainly from innovative services in Australia and the United States. CRTs assess all patients considered for acute admission as quickly as possible, offer intensive home treatment as a substitute for admission whenever feasible, and discharge patients to other services once the crisis has been resolved, usually within a few weeks. CRTs in the United Kingdom are effective in reducing hospital bed use; also, there is some evidence that they improve user satisfaction, and other outcomes appear similar to those that result from standard acute care (8–10). The introduction of CRT in the United Kingdom has attracted substantial interest internationally, and services closely resembling the United Kingdom model are now available in Norway and some parts of Australia and the United States (4). Thus intensive home treatment is an increasingly important service component internationally.

When patients with dependent children are acutely unwell, they often struggle to meet the competing de-

---

*Dr. Khalifeh, Dr. Killaspy, and Dr. Johnson are affiliated with the Department of Mental Health Sciences, University College London, Level 2, Pond St., London NW3 2QG United Kingdom (e-mail: h.khalifeh@medsch.ucl.ac.uk). Dr. Khalifeh, Dr. Johnson, and Dr. Killaspy are also with the Camden and Islington NHS (National Health Service) Foundation Trust, London, with which Dr. Murgatroyd is affiliated. Dr. Freeman is with the Child and Family Department, Tavistock and Portman NHS Foundation Trust, London.*

mands of illness and parenting (11). Their children are at risk of exposure to symptoms, poor parental care, and in some cases neglect or abuse (12,13). The adverse impact of acute mental health crises on parents and their children can be modified by offering appropriate services and support (14). In the past patients experiencing a severe acute mental health crisis were usually hospitalized. Parental hospitalization relieved the parents of the burden of child care and protected the children from the effects of acute illness, but it also exposed children to the trauma of parental separation and placed them at risk of inadequate alternative care (15). Parents worried about short-term separation and the possibility of custody loss over the long term (16), leading in some cases to the avoidance of mental health professionals when acutely unwell (11). More recently, parents in an acute crisis have been offered home treatment as an alternative to hospital admission. In order to investigate the relative merits of home treatment versus hospital admission, we explored the experiences, treatment preferences, and unmet needs of parents who were treated at home for an acute mental health crisis by using a qualitative study design.

## Methods

### *Setting and participants*

This study was carried out in the inner London boroughs of Camden and Islington, which have a total population of 373,817. High levels of deprivation give this area one of the highest estimated levels of psychiatric morbidity in the United Kingdom (17). In these two boroughs patients presenting with a mental health crisis severe enough to require hospital admission can be treated in one of three settings: at home (by one of four CRTs), in a hospital, or at a crisis house for women only (18). The latter can accommodate 12 women and up to four children for up to four weeks. Local service policy recommends the assessment of needs of children of any patient, and where there are concerns a referral should be made to the local Children and Families Social Services.

We recruited female patients treated by a CRT in the previous 18 months. Inclusion criteria were full or

partial responsibility for a child younger than 18 years, proficiency in spoken English, stable mental state at the time of interview, and ability to give informed consent to participate in the study. Patients were not approached to participate in the study if they had recently lost custody of a child, in order to avoid insensitivity and potential distress. We used purposive sampling to recruit patients with different diagnoses, treatment histories, levels of social support, and children's ages. Patients were identified through CRT staff. For patients who were under the care of a community mental health team, the team was contacted to ascertain the patient's most recent contact and mental state. Eligible patients were sent an information sheet and a consent form and were then contacted by phone by CRT staff, community mental health team staff, or the researchers, as appropriate. After full explanation of the study aims and an opportunity to ask questions, informed written consent was obtained from those willing to participate. Interviews took place at a location of the participant's choice. After the interview the women were given two information sheets on parental mental illness, one that was aimed at parents and was produced by the mental health charity Mind ([www.mind.org.uk](http://www.mind.org.uk)) and another that was aimed at children and was included in a Department of Health training manual (15). Participants were given a £10 voucher in appreciation of their time.

After completing interviews with the mothers, we conducted further interviews with their children, in order to triangulate the findings. We sought permission from all parents of children aged 12 to 18 years to contact these children. Information sheets and consent forms were then sent to the children, and informed written consent was obtained from those willing to participate. Children were given the option of being interviewed alone or with a family member present. They were given a £10 voucher in appreciation of their time. The study was approved by the local research ethics committee.

### *Data collection*

A semistructured interview was used. The interview topic guide was based

on previous research in the area (11,15,16) and on the specific aims of the study, which were to explore the following: patients' experiences of home treatment, children's experiences of home treatment, treatment preferences, and unmet needs.

Interviews with patients were conducted over a six-month period in 2006 and 2007 by one of two researchers (HKh or CM). Both researchers are specialist registrars in general adult psychiatry and were not directly involved in the participants' clinical care. Interviews with the children were carried out by MF, a specialist registrar in child and adolescent psychiatry, with a semistructured interview to explore themes emerging from the maternal interviews.

### *Analysis*

All interviews were audiotaped and independently transcribed. Information identifying the interviewer was removed. Content analysis was carried out with the support of QSR N6 NUD\*IST software (19). A coding frame was developed that contained themes relevant to the aims of the study. The interview guide topics were the starting point, and they were included as themes in the coding frame at the beginning of the process of analysis. The coding frame was then elaborated and modified as new themes and subthemes emerged in the course of the analysis. The development of the coding frame thus combined deductive elements (based on a priori themes to be explored) and inductive elements (based on themes emerging directly from the data) (20). Negative case analysis was used to refine the coding framework, by searching for elements of the data that seemed to contradict emerging themes. Interviews were analyzed throughout the study period in groups of two to four interviews, with findings used to refine the interview schedule and guide further analysis.

All patient interviews were independently coded by HKh and CM. All child interviews were independently coded by HKh and MF. A consensus on the final coding frame was established through discussion with all coders.

**Table 1**

Characteristics of 18 mothers in London who received home treatment for a severe acute mental health crisis

Characteristic	N	%
Age		
21–30	1	6
31–40	9	50
41–50	7	39
51–60	1	6
Race or ethnicity		
White	12	67
Black	3	17
Asian	3	17
Living circumstances		
Alone	9	50
With child's father	8	44
With other male	1	6
Number of children		
1	6	33
2	3	17
3	5	28
4	4	22
Children's age		
0–1	3	7
2–5	8	19
6–11	13	30
12–18	16	37
>18	3	7
Past or current involvement with Children and Families Social Services		
Yes	5	28
No	13	72
Diagnosis		
Major depression	10	56
Bipolar disorder	6	33
Schizophrenia	2	11
Past treatment setting		
None	2	11
Hospital	10	56
Crisis house for women	2	11
Crisis house for women and hospital	4	22

## Results

### *Participant characteristics*

Of the 35 patients we attempted to contact, 18 (51%) agreed to participate, seven (20%) could not be contacted, and ten (29%) declined to participate. The demographic and clinical characteristics of participants are outlined in Table 1. Of note is that half of the participants were single parents. Five (28%) had past or current involvement with Children and Families Social Services. Four (22%) had children on the “at need” register through Children and Families Social Services, where a family is assessed as requiring additional support without

significant risk issues, and one (6%) had children on the “at risk” register, because there was significant concern about child abuse or neglect.

Nonparticipants were more likely than participants to have a psychotic illness (four of 17 nonparticipants, or 24%, compared with two of 18 participants, or 11%), but there were no differences in treatment history, the number or ages of children, living circumstances, or involvement of social services.

Of the ten mothers with children aged 12 to 18 years, four gave consent for their children to be approached for interview and six could not be contacted. Two children of these four consenting patients did not attend arranged interviews and could not be subsequently contacted. Five children from two families composed the final sample (two siblings from one family and three from the other). Children were aged 12 to 18 years and lived either with both parents or with the father. All children had significant contact with the mother during the crisis, and they had also experienced maternal hospitalization in the past.

### *Thematic analysis*

*Mothers' experiences of home treatment.* Overall, the positive aspects of being treated at home related to participants' needs as patients, whereas the negative aspects related to their roles as parents. The two most commonly described advantages of home treatment were receiving good-quality care from the CRT and avoiding unwanted hospital admission. One mother said, “They [the CRT] were really good, you know, and they sort of understood as well. They didn't look at you like you were from cuckoo land . . . they're always polite, always there for you.” Another mother described how she preferred home treatment over hospitalization when she said, “[The] hospital is like a German concentration camp, you know.”

Disadvantages to home treatment commonly described by patients were all related to difficulties with parenting while in crisis, with the following five common themes emerging. The first theme consisted of difficulty in meeting the children's physical needs and maintaining normal boundaries.

One single mother of two young boys said, “I found that there were no boundaries. . . . I didn't feel like cooking, so what I would do is spend money that I didn't have, and just give them money to buy takeaways and things like that, and letting them play out[side] when normally I would put my foot down.”

The second theme involved a lack of emotional connectedness with the children. A single mother of two teenage girls said, “I feel numb, and I feel like I've got no feeling . . . and that bugs me a lot. It's really hard. I mean, I know I do love them, but I don't feel nothing.” A mother of a toddler expressed the same types of feelings when she said, “I just felt that I wasn't really necessarily interacting with her well because I was so switched off. . . . I just felt within myself that I was failing as a mother.”

The third theme involved exposing the children to distressing symptoms or behaviors. A married mother of three young and teenage girls said, “When I self-harmed, she went in her bedroom, and she picked up her dolly blanket and put it over my head, and she said, ‘Don't do it, mummy, it's sore.’ And she was only two.” And a single mother of a teenage boy said, “[My son] said, ‘You used to sit out there half naked, and the way you sat in your sarong and you didn't have any underwear on, and it was disgusting.’ And I had no idea that I wasn't properly dressed.”

The fourth theme consisted of directly incorporating the children in their symptoms. For example, a married mother of four boys aged four to 18 years said, “There was this dreadful thing where I thought about him [one of my sons] being put in an oven, and it completely and utterly freaked me out, to be honest with you. . . . I'd never in a million years want to put him in an oven, you know.”

The fifth theme involved burdening the child with caregiving responsibilities. One single mother of a teenage boy said, “I'm reliant on him physically to go to bed, physically to get up, emotionally because he's my one and only contact. And it's almost like sometimes I am the child, and he's the parent.”

*Children's experiences of home*

treatment. We explored participants' perceptions of their children's experiences and needs during home treatment, and we compared themes emerging from the parent and child interviews. Although parents were able to describe their own struggle to meet the children's needs, most appeared to have difficulty in reflecting on what the children themselves experienced, thought, and felt. They described this difficulty as being mainly due to poor communication, both during the crisis and afterward. The shaded box on this page lists common themes for poor communication between parents and children and provides quotes as examples. Some parents were able to describe the confusion, worry, anger, and resentment that their children felt during the crisis. One extreme example was given by a woman whose son once wished she would commit suicide, so as to gain relief from the responsibility of caring for her. This single mother said, "I can't remember if it was 75% or 25% of people who are bipolar commit suicide. And he said, 'Do you know what I thought, mum? And this is really, really what I thought. I thought, yeah, why doesn't she just do it? Then we'll have a funeral, it will all be over, and I'll just be the poor boy who lost his mum.' . . . [He said this] because of the responsibility of me . . . the emotional responsibility."

Overall, the children's accounts of parental home treatment were negative. Children gave detailed and rich examples of the general worries highlighted by parents, such as the parent's inability to provide care and the role reversal where the child tried to protect the parent. One child said, "If I'm hungry, I don't want my mom to go near a cooker . . . if my mom's ill, she tells me that she has little people in her head talking to her, so she's got them in her head, and then she's not really focusing on what she's doing, so she might burn herself, or set the house on fire. So I'd prefer that not happen. I just let my mum rest."

In addition, some children described stresses that were not mentioned by any of the mothers. These included feeling that their mother was aggressive toward them and feeling

frightened of her. One child said, "I just don't like to be around when she's like that, because sometimes she can be . . . not aggressive, but . . . sometimes if my mum's ill, I think she's taking it out on me, or my sister, or things, so we get the wrong end of it. . . . sometimes my mum just doesn't know what she's saying, half of the time. So I take it offensively, or something." Another child said, "Through that whole time my mum was ill I felt scared . . . I was quite upset."

*Treatment preferences.* All but two participants had been treated in more than one setting, either during the most recent episode of illness or in the past. Most participants who had been treated in a hospital preferred home treatment to admission (12 of 14 participants, 86%), because they felt safer and better looked after at home. Conversely, all six participants admitted to a crisis house preferred this to being treated at home, mainly because of parenting issues: they were overwhelmed by parenting responsibilities at home and felt the children would benefit from their admission. One single mother of a

young boy said, "There was a point where I just managed, and there was a point where I knew I couldn't do it anymore. I couldn't run the whole struggle, not even look after myself, much less to look after a child."

Unlike the parents, most of the children we interviewed (four children, 80%) said that they preferred it when their mother was admitted rather than treated at home. When their mother was admitted, the children worried less and felt she was better looked after. One child described a "balancing act" between his own preference for hospital treatment and the mother's preference for home treatment. He said, "For the first couple of weeks while she's in hospital, I felt more happy, because I knew she's safe in hospital and nothing can go wrong. . . . But when she's at home, because she's with me, is that a sign that she's going to be happier, instead of locked away in the hospital? . . . So I mean it's a bit of a balancing act."

*The role of the extended family.* Half the participants had the help of partners, parents, or siblings during

### ***Perceptions of mothers with severe mental illness of the reasons for poor communication with their children***

#### **Parent too ill**

"I think when I was really ill I didn't know what was really . . . going on as such. I might have just said the odd little thing here, there, and everywhere. But I know I certainly didn't sit down and discuss it with him, which maybe, perhaps, I should have done."

#### **Parent's poor understanding of her illness**

"They don't really understand my illness, and I don't understand my illness either, so it's so hard to talk about it. It's shoved under the carpet."

#### **Parent's wish to protect child**

"I haven't gone into it with them, because I don't want them to worry about anything."

#### **Parent's perception of child's understanding**

"Well I haven't said much to them. They know things, don't they? They understand, you know."

#### **Parent not primary caregiver**

"They tend to want feedback they have from the parent who is looking after them, don't they really? You don't know what they [the children] say. They could be saying anything really. But they've never said anything to me."

#### **Child's openness**

"He's not very good about talking about things. He tries to blank things out. But he's had a hard time, you know, and he's very damaged because of it."

#### **Child's age or development**

"She couldn't necessarily communicate with me to say that oh, you know, 'Why are you acting that way, mummy,' or something like that. At least if she's a bit older she maybe could have said something."



the crisis. Many found this supportive, especially with respect to practical child care. However, some participants described their sadness or worry at the loss of their parenting role. A few described partners being critical of them and their illness and using the illness to turn the children against them. One mother said, "He just didn't want me in their lives at all; he just tried everything to keep me out, you know. [He said things like,] 'You're mad; we don't want you.'"

The children we interviewed had the support of their father during the crisis. These children described the key role of the father and siblings in protecting them against the full impact of the crisis. One child said, "I felt scared . . . I was quite upset . . . but because I had my dad to turn to, and I had older brothers, it kind of blocked the way of how I felt . . . in a way they kind of, like, defended me, like, nothing got through."

*Unmet needs and the role of professionals.* Overall, participants were satisfied that their needs as patients were well met by CRT staff. Although most participants described significant difficulties with parenting (N=16, 89%), only three of these parents (19%) described wanting more professional help with this. When parents talked about parenting and getting help from professionals, a majority were preoccupied with the worry that their parenting would be negatively judged or that the children would be taken away. One single mother of two young boys said, "I felt that are they thinking that I'm not a capable mum, having said that I want to throw myself out the window, you know." And a mother of one toddler said, "I felt as if, because of my actions of how I was, I was so switched off that possibly someone who was professional would come in and take her away."

Only a few children had more than passing contact with professionals from the CRT or social services during the crisis (N=5, 28%). However, in families where there was significant professional contact with the children, participants found this helpful rather than threatening, both for the parent and the child. One mother of a toddler said, "They always mentioned that she was very happy and

not to worry about it. That made me feel as if it wasn't that bad, and I was maybe overreacting a bit." A single mother of a teenage boy said, "He felt involved, and he felt empowered, and he felt appreciated."

Some children mirrored the parents' reluctance to seek help from professionals, preferring to access help via the family. One child said, "I prefer it if they told my parents, and they [the parents] told me back, because that's better than some person I hardly know tell[ing] me, because they, I wouldn't mind speaking with them, but I prefer it if it's from my parents."

## Discussion

The main findings of this study were that mothers treated at home were positive about the quality of care they received as patients, but they struggled to provide adequate parenting. They found it difficult to reflect on the children's needs and to access help for the children from professionals. Children described difficulties not highlighted by parents, such as hostility from parents and fear of them. Despite the difficulties, many patients preferred home treatment over hospital admission, where they felt safer and better looked after. In contrast, most children preferred parental admission, because it relieved them of worry. Both parents and children were positive about admission to a crisis house. The findings from this study suggest that although home treatment may meet patients' treatment needs, children may be exposed to a number of risks, such as parental hostility, poor parental insight, poor communication, and lack of access to professional support.

Before the implementation of CRTs, parents in acute crisis who presented to services were hospitalized. Previous qualitative studies show that parents are insightful and articulate about their difficulty in meeting the children's needs in a crisis and about the potential benefits of hospital admission (21). This is the first study to investigate experiences of home treatment as an alternative to psychiatric admission. We found that although mothers were insightful about their difficulty in providing adequate parenting during home treatment,

this did not influence their treatment preference—most preferred home treatment over hospital admission. As with previous studies, our study found that although mothers recognized the child's need for support, they were often reluctant to seek professional help because of fear about custody loss or the wish to protect the child (11). We found that parents struggled to reflect on the children's own experiences and needs. This mirrors past studies, where accounts of children's experiences by parents and by the children themselves were found to differ, because the parents' accounts were in part colored by their mental state and anxieties (22). It is of note that although patients in this study focused on the harmful effect of lack of care, children themselves were more distressed by parental hostility and fear of their parents. Past studies highlight parental hostility as an important risk factor in child morbidity, especially when the child has a poor understanding of parental illness and behavior (23). The risks may be attenuated by offering families psychoeducational interventions, which have been shown in randomized clinical trials to improve communication and reduce child morbidity (24,25).

The qualitative design of our study is well suited for exploration of patients' experiences and views. We attempted to make our sample as representative as possible by purposively selecting people with the range of diagnoses and characteristics likely to be encountered by any CRT. The participants had varied past treatment experiences, allowing for in-depth exploration of treatment preferences. Triangulation through interviews with the children allowed for exploration of the emergent themes from an alternative perspective and pointed to potential conflict of preferences and interests between children and parents. However, the findings of our study were limited by the relatively low participation rate, and it is possible that women with a positive experience of home treatment were more likely to participate. Hence our findings cannot be considered fully representative of CRT patients with children. We were able to interview only a small sample of children, but these

children raised important concerns not mentioned by their parents, and these views have not been previously explored in other studies. The study focused on mothers, not fathers. The latter group may have unique experiences and needs and warrant an independent study.

## Conclusions

This study suggests that mothers with child care responsibility who experience an acute mental health crisis prefer home treatment to hospital admission but that their children may subsequently be exposed to significant risks. When these parents are admitted to a hospital, the care and safety of their children are likely to be considered, especially if the patient is a single parent, and this may involve assessments by statutory organizations such as Children and Families Social Services. We suggest that when these patients are treated at home, the assessment of their children's needs is as important for patients as it is for those treated in the hospital.

Currently a major impediment to parents' seeking help with child care during a mental health crisis is fear of losing custody. Ready access to support from a source other than the agencies that implement child protection legislation may be a better alternative. Where there is a high proportion of CRT service users who have children, staff members who have specialized training in family support may be able to access additional help for the family during the crisis. Relatively simple interventions, such as access to nursery day care or home child care, may be effective at reducing parental distress and risks to the children, particularly for more socially isolated parents. Specialist projects for young caregivers, including children of people with mental illnesses, may also have a role. For example, Cooklin (26) described how young caregivers found a series of workshops useful and popular. In these workshops young caregivers were encouraged to express their feelings and experiences through storytelling and games. Enhanced access to such projects at the time of a crisis may fulfill some of the main needs of children who are caregivers for parents with

mental illness—that is, it gives children a place where they can have a frank discussion of their situations, have contact with others with similar experiences, and receive guidance on how to respond to their parents (26).

When parents are treated at home for an acute mental health crisis, both parents and children struggle to cope, but they are reluctant to seek professional help. A significant proportion of psychiatric patients have child care responsibility, and there is an international trend toward home treatment for all phases of illness. The challenge for service providers is to develop acceptable and accessible help for families, incorporating interventions that address unmet needs and barriers to help seeking that have been articulated by the families themselves.

## Acknowledgments and disclosures

This study was funded by the Department of Mental Health Sciences, Hampstead Campus, University College London.

The authors report no competing interests.

## References

- Howard LM, Kumar R, Thornicroft G: Psychosocial characteristics and needs of mothers with psychotic disorders. *British Journal of Psychiatry* 178:427–432, 2001
- Oates M: Patients as parents: the risk to children. *British Journal of Psychiatry* 170(suppl 32):22–27, 1997
- Blanch AK, Nicholson J, Purcell J: Parents with severe mental illness and their children: the need for human services integration. *Journal of Mental Health Administration* 21:388–396, 1994
- Johnson S, Needle J, Bindman JP, et al (eds): *Crisis Resolution and Home Treatment in Mental Health*. Cambridge, United Kingdom, Cambridge University Press, 2008
- Joy CB, Adams CE, Rice K: Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews* CD001087, 2004
- National Service Framework for Mental Health: Modern Standards and Service Models. London, Department of Health, 1999
- The NHS Plan: A Plan for Investment, a Plan for Reform. London, Department of Health, 2000
- Johnson S, Nolan F, Houlst J, et al: Outcomes of crises before and after introduction of a crisis resolution team. *British Journal of Psychiatry* 187:68–75, 2005
- Bourn J: *Helping People Through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services*. London, National Audit Office, 2007
- Johnson S, Nolan F, Pilling S, et al: Randomized controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. *British Medical Journal* 331:599, 2005
- Nicholson J, Sweeney EM, Geller JL: Mothers with mental illness: I. the competing demands of parenting and living with mental illness. *Psychiatric Services* 49:635–642, 1998
- Garley D, Gallop R, Johnston N, et al: Children of the mentally ill: a qualitative focus group approach. *Journal of Psychiatric Mental Health Nursing* 4:97–103, 1997
- Hall A: Parental psychiatric disorder and the developing child, in *Parental Psychiatric Disorder: Distressed Parents and Their Families*. Edited by Gopert M. Cambridge, United Kingdom, Cambridge University Press, 2004
- Falkov A, Lindsey C (eds): *Patients as Parents: Addressing the Needs, Including the Safety, of Children Whose Parents Have a Mental Illness*. London, Royal College of Psychiatrists, 2002
- Falkov A (ed): *Crossing Bridges: Training Resources for Working With Mentally Ill Parents and Their Children*. London, Her Majesty's Stationery Office, 1998
- Wang AR, Goldschmidt VV: Interviews with psychiatric inpatients about professional intervention with regard to their children. *Acta Psychiatrica Scandinavica* 93:57–61, 1996
- Glover GR, Robin E, Emami J, et al: A needs index of mental health care. *Social Psychiatry and Psychiatric Epidemiology* 33:89–96, 1998
- Killaspy H, Dalton J, McNicholas S, et al: Drayton Park, an alternative to hospital admission for women in acute mental health crisis. *Psychiatric Bulletin* 24:101–104, 2000
- Richards T, Richards L: Using computers in qualitative research, in *Collecting and Interpreting Qualitative Materials*, 3rd ed. Edited by Denzin N, Lincoln Y. Thousand Oaks, Calif, Sage, 2007
- Pope C, Zieband S, Mays N: Qualitative research in health care: analyzing qualitative data. *British Medical Journal* 320:114–116, 2000
- Diaz-Caneja A, Johnson S: The views and experiences of severely mentally ill mothers: a qualitative study. *Social Psychiatry and Psychiatric Epidemiology* 39:472–482, 2004
- Boyle MH, Pickles AR: Influence of maternal depressive symptoms on ratings of childhood behavior. *Journal of Abnormal Child Psychology* 25:399–412, 1997
- Rutter M, Quinton D: Parental psychiatric disorder: effects on children. *Psychological Medicine* 14:853–880, 1984
- Beardslee WR, Gladstone TR, Wright EJ, et al: A family-based approach to the prevention of depressive symptoms in children at risk: evidence of parental and child change. *Pediatrics* 112:e119–e131, 2003
- Clarke GN, Hornbrook M, Lynch F, et al: A randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed parents. *Archives of General Psychiatry* 58:1127–1134, 2001
- Cooklin A: Children as carers of parents with mental illness. *Psychiatry* 5:32–35, 2006